Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement for an office visit.

   b. The request was received on August 20, 2002.

II. EXHIBITS

1. Requestor, Exhibit 1:

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. HCFA's
   c. EOB
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit 2:

   a. TWCC 60 and/or Response to a Request for Dispute Resolution
   b. Medical Records
   c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on September 20, 2002. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on September 20 2002. The response from the insurance carrier was received in the Division on October 4, 2002. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Medical Dispute is reflected as Exhibit #3 of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: The requestor states in the correspondence dated July 17, 2002 that… "…We billed CPT code 99214 for an office visit for evaluation and management of an established patient. This code requires at least two of the three key components. The patient has a detailed history including chief complaint, history of present illness and review of systems. The patient has a detailed examination including general appearance, evaluation of his vascular system, evaluation of his lymphatic system, evaluation of his skin, evaluation of his mood and orientation, evaluation of his neurological reflexes and sensation and evaluation of his muscular skeletal system, including gait, range of motion, muscle strength and pain. This is greater than twelve areas for a detailed physical examination. He also has a moderate decision making process which includes diagnosis and management options and evaluation of his x-rays and the complexity of his injury…"

2. Respondent: The respondent states in correspondence dated October 3, 2002 that… "…The requester billed for this level of service, without providing documentation consistent with the level billed. In particular, the requester did not indicate in the record, express or implied, which two of the tree components of management were being performed. The requester's single page note indicates simply that the claimant was in for re-evaluation status post lumbar laminectomy an fusion of 7/6/01, eight months prior to the office visit on March 11, 2002. Medications were continued and no other medical recommendation was made. There are no objective measurements to qualify the requestor's subjective statements… However, the documentation does not support a detailed history or medical decision making of moderate complexity. Accordingly, this lack of documentation to support the level of office visit billed let the carrier deny reimbursement for a 88214 office visit."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is March 11, 2002.

2. Respondent denied disputed date of service for "F – T, N Documentation does not support he service billed. Therefore, disputed date of service will be review per the *1996 Medical Fee Guideline* and TWCC Rules.

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$ (Maximum Allowable Reimbursement)	REFERENCE	RATIONALE:
03/11/02	99214	$71.00	$0.00	F – T, N	$71.00	MFG, E/M Ground Rules (IV)(C)(2) Rule 4083021(a)	Requestor's submitted office visit notes supports payment at the level of service billed. Two of the three components were met; therefore, reimbursement in the amount of $71.00 is recommended.
Totals		$71.00	$0.00				The Requestor **is** entitled to reimbursement in the amount of **$71.00**

VI. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $71.00 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

This Order is hereby issued this 6th day of February 2003.

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf